PRINTED: 06/25/2008

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G214 05/30/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5701 14TH STREET, NW** METRO HOMES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 000 INITIAL COMMENTS W 000 On 5/13/2008, the Department of Health received notice of Client #1's death. The information obtained revealed that on 4/2/2008. Client #1 was hospitalized due to unresponsiveness. Client #1 was transported to the Emergency Room (ER) D and was admitted for emergent care. Client #1 passed away on the morning of 5/13/2008. The cause of death remains unknown to date. Upon her admission to Metro Homes on 3/3/2008, Client #1 was diagnosed with the following medical conditions: Congenital heart disease (mitral valve), VSD. HBV carrier, S/P Mastoidectomy 1986, B/L Cataracts, abnormal gait, B/L Pes Planus. Seborrheic dermatitis, Scoliosis, Chronic Otitis Media, Severe Esophageal Motility D/O, H/O silent aspiration, Onychomychosis, S/P Blepharitis, H/O Left knee cellulitis, Subluxation deformity of the left thumb, S/P polyectomy. Osteoarthritis, Myopia, mild Hyperproliferative bone marrow, H/O Macrocytosis, Leucopenia right thumb fusion. Athlete's foot, recurrent UTI. Hypokalemia. Due to the nature of this incident, an on-site investigation was initiated on 5/22/2008. At the conclusion of the survey, there were evidence and incidental findings to support that the facility was out of compliance with a few standard level regulatory requirements. The deficiencies identified in this report were based on interviews with the nursing staff, management staff, direct care staff and record reviews. The findings were also based on a review of the clinical and medical records as well a review of the unusual incident reports. 483.410(a)(1) GOVERNING BODY W 104 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	The governing body	y must exercise general policy, ing direction over the facility.	W 104	W 104 The Agency was in	6/25/08	
-	Based on staff inter facility failed to ensure address medical proclients health and some clients health and some clients health and some clients health and some client #1 was admit without a complete available. Apparent history was later four of MRSA. It is not conceived this information measures were enaugative of MRSA. It is not conceived this information and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived this information and all residents we negative of MRSA. It is not conceived this information and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents we negative of MRSA. It is not conceived the remain and all residents in the remain and all r	ted to the facility on 3/3/2008 medical history being made tly, Client #1 's medical and to include the diagnoses clear exactly when the facility ation, but preventive cted to ensure the health and ing residents in 5/22/2008 re tested for and found On 5/22/2008 at 1:23pm, the Mental Retardation or revealed the policies were prevented the policies were assessments for assessments for accility conducted an internal esituation on 5/19/2008 and all amend or modify its include that all individuals from long term care at ghomes are tested for eat individuals immediately		conversation with Dr. Bu from Providence Hospital regards to the MRSA epis with hospitalized clients.  On 6/25/08 we received confirmation that Provide Hospital had instituted a MRSA screening Policy fo in patients.  The Agency has now amended its admission poto include the MRSA screening.  See attached Providence Hospital Policy and Metro Homes policy.	ence or all	

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	A secondary interving Registered Nurse Strevealed that the change of the address MRSA addiseases were still preview on 5/30/2003 remaining residents MRSA and were test MRSA and were test time of survey to sulvere amended as rehealth and safety of 483.430(e)(1) STAFT The facility must proinitial and continuing employee to perform efficiently, and compart of the standard of the safety facility failed to ensure clients.	ew with the facility 's Supervisor on 5/30/2008 hanges in the admission policy and other communicable pending. Additional record 8 revealed that all five of the exercised on 5/22/2008 for sted to be negative.  Ince presented or on file at the bstantiate that the policies ecommended to ensure the startiate that the policies ecommended to ensure the fits residents.  FTRAINING PROGRAM evide each employee with a training that enables the main or her duties effectively, betently.  Incommended to ensure the starting that enables the main or her duties effectively, betently.	W 1	DEFICIENT 104	or who ait have a apleted. the es to be staff are	6/25/08	
	Interview with the Quencies sional (QMRP) direct care staff on 5 sustained a fall from Record review on 5/2 did occur as garnere Additional record revito ensure that all staff	palified Mental Retardation (), House Manager (HM), and (/22/2008 revealed Client #1 her wheelchair on 3/26/2008. (22/2008 reflected this event () during the interviews. () lew revealed the facility failed () final received training on () evention Protocol " prior to		fall protocol.  See attached trainin Protocol.			

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	her fall. In addition, that all staff receive after the incident as on file or presented substantiate that the staff training measure health and safety with prior to the occurrent Reference W249] 483.430(e)(4) STAF Staff must be able to techniques necessal program plans for exponsible.  This STANDARD is Based on staff intentiacility failed to ensuring preventing preventing preventient's health and shabilitation plan for othe facility. [Client # The finding includes Record review on 5/30/2008 revealed thave Osteoporosis a record review reveal from her wheel chair the facility's House revealed she was in heard Client #1 fall in and the incident repoplaced in front of Client preventive measure	the facility failed to ensure d training on said protocol well. There was no evidence at the time of survey to a facility employed effective ares to ensure Client #1 's ith regards to fall prevention are of the incident. [Cross of TRAINING PROGRAM of demonstrate the skills and any to implement the individual ach client for whom they are its staff was capable of intive measures to protect a safety as outlined in the one of five clients residing in 1]:  22/2008 and again on Client #1 was diagnosed to and Osteopenia. Additional ed Client #1 sustained a fall on 3/26/2008. Interview with Manager (HM) on 5/22/2008 the dining area when she of tindicated a pillow was	W 1		W 194  The client was not sittin her wheelchair and was alone during the time of incident. She was sitting regular single seated sof was being assessed by the Speech Therapist during time of the incident. The client had a bed standard pillow placed in front of when she was seated in the sofa. She did not have a few but rather slid onto the few from the 1.0 foot high socchair, which belonged to client, and landed on the pillow. She sustained no overt injuries and proper protocol was followed after the incident.	not the in a fa and ne the d size her the fall loor fa the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 200	of Client #1 's chair revealed Client #1 v Prevention Protocol event. The docume "Staff will assist her someone is sitting in is in the chair. A pill at the foot of her chair will assist her to sit it ensuring that her broappropriately and the whenever she is in the trained to implement clarify or address with eliving room or if the management of the fall.  483.440(b)(3) ADMIST DISCHARGE  A preliminary evaluation information as well a assessments of function behavioral, social, he determine if the facility needs and if the client placement in the facility failed to acquitation facility failed to acquitation in the facility failed to acquitation.	ge a pillow was placed in front.  Further record review was provided with a "Fall "[FPP] to prevent such an ent outlines that.  To sit in her chair only if ext to her for as long as she low is advisable to be placed air when she is in it Staff in her wheelchair and akes are put on and off e straps are fastened he wheelchair."  Ed an internal investigation of the FPP, but failed to make the FPP, but failed to make in straps "were properly was sitting in the chair prior SSIONS, TRANSFERS,  Ition must contain background is currently valid ealth and nutritional status to ty can provide for the client's at is likely to benefit from	.W 200	The Incident Manageme Coordinator failed to interview the Speech Therapist or get her statement.  In the future the IMC will ensure all persons witne an incident are adequate interviewed and appropristatements are written to reflect actual facts.  See attached Speech Therapist's statement	I essing ely riate	

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	The finding includes Interview with the fathurse on the afternous not aware Clier prior to her admission a secondary intervies Registered Nurse (Fafternoon of 5/30/20 finding. According the facility did not received records until several (delivery date unknown) recalls that the facility at the time discharge document was being released the medical records Client #1 were spars Record review on 5/3 admission document a history of seizure/s the most recent Phys 5/2008 also did not librorided at that time presented revealed the admission to Provided experienced an onse resulting findings and #1] being prescribed the recommendation at Providence Hospit record reveal the follows.		W 200	W 200  At the time of the admiss the DON and the VP of Operations had a conversation with the discharging Physician from the previous agency, Dr. Potts. He absolutely refut the diagnosis of seizure disorder although the Elementioned it on 2 occasi 8/03/07 and 12/25/07.  The Primary Care Physic would not confirm the diagnosis of Seizure Disoull she was seen and diagnosed by a Neurological however he deferred a neurology consult as she no neurological deficits selence the diagnosis and treatment were not included the physicians order sheets.	rom Ited R had ons – Itan Itan Itan Itan Itan Itan Itan Itan	6/28/08

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	HOMES, INC				5701 14TH STREET, NW WASHINGTON, DC 20011		
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	activity 2. 12/16/2007 - Tri status. 3. 11/05/2007 - Tri Infection (UTI). 4. 08/03/2007 - Tri and for seizure activ It is not clear if Clien 4/2/2008 was related levels, seizure activi if the facility was awa history of fluctuating prior to admission. In that the medical recordacility did not have a health at the time of providing care based on record at the time 483.460(a)(3) PHYS The facility must pro- general medical care This STANDARD is Based on staff interv facility failed to ensur medical follow-up to safety. The finding includes: Record review on 5/2 5/30/2008 revealed C to have Osteoporosis record review revealed	eated for altered mental eated for Urinary Tract eated for Hypokalemia, UTI city.  It #1 's hospitalization on d to her fluctuating Potassium ty or both. It is also not clear are of Client #1 having a mineral levels and seizures What was ascertained was ords were incomplete and the a clear picture of Client #1 's admission and was only d on the information they had e. [Cross Reference W104] ICIAN SERVICES	W 3		W 322  After the fall the Prima Care Physician did not any radiological service the client did not fall buunto the pillow on the f She did not sustain any injuries and the PCP did recommend radiology.  The PCP did however or wheelchair assessment achest harness.	order es as at slid loor. I not	6/25/08

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	the facility's House revealed she was in heard Client #1 fall time, staff rushed to condition, notified the was later assessed House Manager (Hildetailed that a pillow #1's chair as a prefall. It must be note hardwood and it is rwas placed in front record review reveawith a "Fall Prevensuch an event. The investigation into the #1] may have beneficially beneficially wheelchair on Marc. Osteoporosis and Costeoporosis and Costeoporosis and Costeoporosis and Costeoporosis of Osteoporosis of Osteoporosis of Osteoporosis of Osteoporosis of Osteoporosis of Osteoporosis and control safety was completed.  483.460(c)(5)(ii) NU  Nursing services must other members of the appropriate protection measures that included control of communic	e Manager (HM) on 5/22/2008 in the dining area when she in the living room. At that in the living room. At that in the aid to check on her he nurse on duty and Client #1 to be without injury. Both the M) and the incident report in was placed in front of Client inventive measure prior to the ed, the facility 's main floor is not clear how large a pillow of Client #1 's chair. Further aled Client #1 was provided attion Protocol "to prevent infacility conducted an internal efall and concluded "[Client internal efall out of her heat the time of notiate that given he known or on file at the time of notiate that given the known or on file at the time of notiate that given the known or on file at the time of notiate that given the known or on file at the time of notiate that given the known or on file at the time of notiate that this client 's as intact was never.  RSING SERVICES  st include implementing with the interdisciplinary team, we and preventive health the but are not limited to able diseases and infections, ion of other personnel	W 322			

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE :	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L  Continued From pa  This STANDARD is Based on staff interfacility failed to ensimanage and care for diagnosed with hav [Client #1]  The finding includes  Interview with the facility being made medical history was diagnoses of MRSA  It is not clear exactly this information, but preventive measure mealth and safety of all clients were tested and were found to be conclude the manager and were found to be staff when they received the staff to date to manager are diagnosed with staff was trained to a sevidence of the train	O9G214  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff was trained to manage and care for clients who have been diagnosed with having communicable diseases.	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 8  This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff was trained to manage and care for clients who have been diagnosed with having communicable diseases. [Client #1]  The finding includes:  Interview with the facility 's Registered Nurse Supervisor on 5/30/2008 revealed Client #1 was admitted to the facility without a complete medical history being made available. Client #1's medical history was later found to include the diagnoses of MRSA.  It is not clear exactly when the facility received this information, but the RN Supervisor stated that preventive measures were enacted to ensure the nealth and safety of the remaining residents and all clients were tested for MRSA on 5/22/2008 and were found to be negative.  Further staff interview revealed the facility 's policies were in process of being revised to include the management of MRSA. Additional ecord review revealed the facility did not train staff when they received notification that Client #1 was diagnosed with MRSA, nor have they trained staff to date to manage individuals who may have or are diagnosed with MRSA, nor have they trained staff to date to manage individuals who may have or are diagnosed with having MRSA. A final interview with the facility 's Registered Nurse Supervisor on 5/22/2008 at 2:27pm revealed "only the nurses [were] responsible for caring for hat skin condition ". In addition, she stated that that was trained to address that problem, but the widence of the training was with the former	ROYIDER OR SUPPLIER  ROYIDER OR SUPPLIER  ROMES, INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff was trained to manage and care for clients who have been diagnosed with having communicable diseases. [Client #1]  The finding includes:  Interview with the facility 's Registered Nurse Supervisor on 5/30/2008 revealed Client #1 was admitted to the facility without a complete medical history being made available. Client #1 's medical history was later found to include the diagnoses of MRSA.  It is not clear exactly when the facility received this information, but the RN Supervisor stated that preventive measures were enacted to ensure the nealth and safety of the remaining residents and all clients were tested for MRSA on 5/22/2008 and were found to be negative.  Further staff interview revealed the facility 's policies were in process of being revised to noclude the management of MRSA. Additional ecord review revealed the facility did not train staff when they received notification that Client #1 vas diagnosed with MRSA, nor have they trained staff to date to manage individuals who may have or are diagnosed with MRSA, nor have they trained staff when they received notification that Client #1 vas diagnosed with MRSA, A final necroir eview revealed the facility 's Registered Nurse Supervisor on 5/22/2008 at 2:27pm revealed " mily the nurses [were] responsible for caring for hat skin condition ". In addition, she stated that taff was trained to address that problem, but the vidence of the training was with the former	CONTINUED FOR SUPPLIER  IDENTIFICATION NUMBER:    09G214	

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NAME OF F	PROVIDER OR SUPPLIER	HFD03-0227	STREET ADDR	EDD CITY 6	STATE, ZIP CODE	05/3	30/2008	
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	notice of Resident # obtained revealed to was hospitalized du Resident #1 was tra Room (ER) and was Resident #1 passed 5/13/2008. The cauto date. Upon her a 3/3/2008, Resident following medical co-Congenital heart dis HBV carrier, S/P Ma Cataracts, abnorma Seborrheic dermatit Media, Severe Esopsilent aspiration, On Blepharitis, H/O Left deformity of the left Osteoarthritis, Myopbone marrow, H/O Nright thumb fusion, Mypokalemia.  Due to the nature of investigation was iniconclusion of the su and incidental findin was out of complian regulatory requirement identified in this repowith the nursing staff care staff and records as well a revirecords as well a revirecords as well a revired to the staff and records as well a revired to the staff and records as well a revired to the staff and records as well a revired to the staff and records as well a revired to the staff and records as well a revired to the staff and records as well as revired to the staff and records as well as revired to the staff and records as well as revired to the staff and records as well as revired to the staff and records as well as revired to the staff and records as well as revired to the staff and records as well as revired to the staff and records as well as revired to the staff and records as well as revired to the staff and records as well as revired to the staff and the staff	sease (mitral valve), ' estoidectomy 1986, E Il gait, B/L Pes Planu is, Scoliosis, Chronic phageal <sup>,</sup> Motility D/O,	mation sident #1 ss. ergency ent care. g of unknown omes on ith the VSD, 3/L s, c Otitis H/O uxation my, rative penia rent UTI, site At the lence er facility rd level es erviews direct gs were il medical					
	réports.							
ealth Requiz	ation Administration	71			<del></del>			
	DIRECTOR'S OR PROVIDE	NAWY The	awhi, ative's signat	BSN,	MA THE	a.	(X6) DATE  L 120 10 6	
TATE FORM			509B	6K	HITT TILE	alvor-c	tion sheet 1 of 8	
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STATE FORM

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/S IDENTIFICAT			A. BUILDIN		(X3) DATE SURVEY COMPLETED	
		HFD03-0227		B. WING _		05/3	30/2008
	ROVIDER OR SUPPLIER	Í			STATE. ZIP CODE		
METRO I	HOMES, INC		WASHING	H STREET, I STON, DC 2	0011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY  SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
1 222	Continued From pa	ge 1		1 222		- <del></del>	
I 222	3510.3 STAFF TRA	AINING	1	1 222			
	There shall be cont training programs s	inuous, ongoing in-se cheduled for all perse	ervice onnel.		I 222		
	Based on staff inter facility failed to ensu	met as evidenced by view and record revieure and received trainealth and safety as obtaine. [Resident #1]	ew, the ning to		refer to W 341		
	The finding includes	5:					
	The facility failed to and trained to mana [Reference 3510.5(c	ensure its staff was p age communicable di c)]	orepared seases.				
<sup>*</sup> 1 226	3510.5(c) STAFF TI	RAINING		1 226			
	Based on staff inter- facility failed to ensu	met as evidenced by: view and record revieure are staff was effective communicable diseas	ew, the		I 226 Refer to W 341		
	The finding includes	:					
,	Supervisor on 5/30/2 was admitted to the medical history being	cility 's Registered N 2008 revealed Reside facility without a com g made available. Re y was later found to in SSA,	ent #1 plete esident		-		
	this information, but that preventive meas the health and safety	when the facility recitive RN Supervisor structed to the remaining restrected for MRSA or	ated o ensure sidents				

	NT OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MUL A. BUILD:	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD03-0227		B. WING		05/	30/2008
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY	, STATE, ZIP CODE		<b>5012000</b>
METRO	HOMES, INC		5701 14TH WASHINGT	STREET, ON, DC	NW 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
1 226	Continued From pag	ge 2		1 226			
	5/22/2008 and were	found to be negative	e.				
	policies were in prod	eived notification that with MRSA, nor have to manage individual gnosed with having I ne facility 's Register 5/22/2008 at 2:27 planses [were] responsible trained to address to dence of the training Mental Retardation 'y who was no longer mpany. There was no resented at the time	i to litional t train Resident they Is who MRSA. A red m nsible for on, she hat was with				
1 310	3516.1 ADMIT, TRA GENERAL PROVISI	NSFER, DISCHARG ON	BE: I	310			
	Each GHMRP shall I clearly describe its a discharge criteria an	dmission, transfer ar	, which nd				
	This Statute is not m Based on staff interv facility failed to ensure address medical pro- residents health and	iew and record revie re changes to their p visions that would er	w the olicies to			ı	
-	The finding includes:						
	Resident #1 was adn 3/3/2008 without a co	nitted to the facility o amplete medical histo	n ory	i	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			A. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
HFD03-0227			B. WING _		05/	05/30/2008	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	<u></u>	
METRO	HOMES, INC		5701 14TH WASHING	H STREET, I STON, DC 2	NW 0011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE	
I 310	Continued From page	ge 3		1310			
	Continued From page 3 being made available. Apparently, Resident #1's medical history was later found to include the diagnoses of MRSA. It is not clear exactly when the facility received this information, but preventive measures were enacted to ensure the health and safety of the remaining residents in 5/22/2008 and all residents were tested for and found negative of MRSA. On 5/22/2008 at 1:23pm, the facility's Qualified Mental Retardation Professional (QMRP) revealed the policies were being revised to address the MRSA problem and to ensure that these assessments for communicable diseases could be addressed prior to admission. The facility conducted an internal investigation into the situation on 5/19/2008 and concluded:  "Metro Homes should amend or modify its Admission Policy to include that all individuals transferred directly from long term care at hospitals and nursing homes are tested for MRSA. In order to treat individuals immediately and prevent infection of others."  A secondary interview with the facility's Registered Nurse Supervisor on 5/30/2008 revealed that the changes in the admission policy to address MRSA and other communicable diseases were still pending. Additional record review on 5/30/2008 revealed that all five of the remaining residents were tested on 5/22/2008 for MRSA and were tested to be negative.  There was no evidence presented or on file at the time of survey to substantiate that the policies were amended as recommended to ensure the health and safety of its residents.			The Agency was in conversation with Dr. Be from Providence Hospit regards to the MRSA epi with hospitalized clients.  On 6/25/08 we received confirmation that Provid Hospital has instituted a MRSA screening Policy from patients.  The Agency has now amended it's admission policy to include the MRS screening.  See attached Providence Hospital Policy and Metr Homes policy.	al in sodes s. I lence or all	6/25/08	
	3517.3 ADMISSION	PÓLICIES PROCEI	DURES	1 322			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
HFD03-0227			B. WING _	···	05/30/2008		
			DRESS, CITY, S	STATE, ZIP CODE	03/3	0/2008	
5701 14			STREET, I	NW .			
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			FROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
1 322 Continued From pa	ige 4		1 322	··· <del>-</del> , ·			
Each GHMRP shall sponsoring agency information about a communicable dise her being admitted. This Statute is not Based on staff interfacility failed to acque records prior to admit [Resident #1]  The finding include Interview with the finding. According facility is Registered the afternoon of 5/3 finding. According facility did not receive admission (delification in the finding included admission were the from the hospital should be further indicate were transferred with and incomplete at the 5/22/2008 revealed documents did not of seizure/seizure or recent Physician is also did not list Seizus part of Resident secondary record recondary record recondar	I obtain from the resi- or guardian, as appropriately known health pro- case of a resident upon or readmitted.  met as evidenced by the work and record revi- uire all pertinent medinitting a resident for a condition of 5/22/2008 review and record review and resident #1 had a high a different with a different with a different with a different with a condary interview with a nurse (RN) Supervisor to the RN Supervisor	opriate, blems on his or ew, the lical care.  actical realed istory of 2008. The visor on e original rithe with the care on ission history the most i/2008 blsorder . A on	n JZZ	At the time of the admiss the DON and the VP of Operations had a conversation with the discharging Physician fit her previous agency. He absolutely refuted the diagnosis of seizure discalthough the ER had mentioned it on 2 occas 8/03/07 and 12/25/07  The Primary Care Physical would not confirm the diagnosis of Seizure Distill she was seen and diagnosed by a Neurolog Hence the diagnosis and treatment were not inclined in the physicians order sheets.	rom e order sions – c cian order gist.	6/28/08	

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		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
HFD03-0227			B. WING _	· · · · · · · · · · · · · · · · · · ·	05/3	05/30/2008	
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			H STREET, N STON, DC 20				
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1 322	Continued From pa	ge 5		I 322			
	provided at that time. The documents that were presented revealed that "shortly after her admission to Providence Hospital [Resident #1] experienced an onset of seizure activity." The resulting findings and tests resulted in " [Resident #1] being prescribed Kepra 250 mg IV BID "per the recommendation of the attending Neurologist at Providence Hospital. Other hospitalizations on record reveal the following medical history:  1. 12/25/2007 - Hyperkalemía and seizure activity 2. 12/16/2007 - Treated for altered mental status. 3. 11/05/2007 - Treated for Urinary Tract Infection (UTI). 4. 08/03/2007 - Treated for Hypokalemia, UTI and for seizure activity.						
	It is not clear if Resident #1 's hospitalization on 4/2/2008 was related to her fluctuating Potassium levels, seizure activity or both. It is also not clear if the facility was aware of Resident #1 having a history of fluctuating mineral levels and seizures prior to admission. What was ascertained was that the medical records were incomplete and the facility did not have a clear picture of Resident #1 's health at the time of admission and was only providing care based on the information they had on record at the time. [Cross Reference W104]  3517.8 ADMISSION POLICIES PROCEDURES  Each GHMRP shall secure a physician 's written report of the health inventory, which shall provide sufficient information concerning the resident 's health including treatment, special diet, or medication orders to enable the GHMRP to provide appropriate services.			I <u>3</u> 30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER  HFD03-0227			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
			B. WING		05/3	30/2008		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS. CITY,	STATE, ZIP CODE			
			H STREET, STON, DC					
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I 330	Continued From pa	age 6	*	1330				
	Based on staff inte facility failed to acq records prior to add	met as evidenced by rview and record reviuire all pertinent med mitting a resident for resident 's history of #1]	iew, the tical care and					
	The finding includes:							
	complete health in s history of seizure	o ensure that a full an ventory included Res s / seizure activity. T her addressed and/o 17.3]	ident #1 ' 'he		1.422		6/27/08	
1 422	3521.3 HABILITATION AND TRAINING			1 422	I 422			
	Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan.		ice with		The client was not so her wheelchair and alone during the tinincident. She was si	d was not ime of the		
	This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff implemented preventive measures as outlined in a resident's habilitation records to ensure a resident's health and safety.  The finding includes:  Record review on 6/22/2008 and again on 5/30/2008 revealed Resident #1 was diagnosed to have Osteoporosis and Osteopenia. Additional record review revealed Resident #1 sustained a fall from her wheel chair on 3/26/2008. Interview with the facility's House Manager (HM) on 5/22/2008 revealed she was in the dining area when she heard Resident #1 fall in the living room. Both she and the incident report indicated				regular single seat which was hers. The had a bed standard placed in front of he she was seated in	he client d pillow ner when		
					She did not have a rather slid onto the			
					from the 1.5 foot h and landed on the sustained no overt and proper protoc followed after the	nigh sofa, pillow. She tinjuries tol was		
	lation Administration	ie are melocitrichort	nuivateu	BRSS	CICLEA	W == 13	uneles els et 7 ess	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPL IDENTIFICATION N		ER/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
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METPO HOMES INC. 5701 14TH			DRESS. CITY. 8 H STREET, 1 STON, DC 21					
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l 422	a pillow was placed chair as a preventive must be noted, the hardwood and it is a was placed in front Further record reviet provided with a "Further record reviet outlines that:  "Staff will assist he someone is sitting ris in the chair. A pill at the foot of her chair will assist her to sit ensuring that her brappropriately and the whenever she is in the facility conduct into the fall and recordinated to implement clarify or address win the living room or	in front of Resident to measure prior to the facility is main floor not clear how large a of Resident #1 is chew revealed Resident all Prevention Protoch an event. The dominant to her for as long low is advisable to be air when she is in it in her wheelchair and the straps are fastene the wheelchair. "  ed an internal investionmended that staff ent the FPP, but faile hy Resident #1 was if her "straps" we when she was sitting	ne fall. It is is is ipillow pair. t #1 was col " ocument oly if g as she e placed Staff d off d igation be ed to left alone re	1 422	The Incident Manager Coordinator failed to interview the Speech Therapist or get her statement.  In the future the IMC ensure all persons with an incident are adequainterviewed and apprestatements are written reflect actual facts.  See attached Speech Therapists statement	will messing ately opriate		